Pharmacy

Prior Authorization Criteria for Overactive Bladder Medications

Background

The overactive bladder (OAB) medications are used to help with symptoms of urge urinary incontinence, urgency, and urinary frequency. Agents in this class include darifenacin (Enablex), fesoterodine (Toviaz), oxybutynin IR (Ditropan, generics), oxybutynin extended release (ER) (Ditropan XL, generics), oxybutynin transdermal delivery system (TDS) (Oxytrol), oxybutynin 10% gel (Gelnique), solifenacin (Vesicare), tolterodine IR (Detrol, generics), tolterodine ER (Detrol LA), trospium IR (Sanctura, generics), and trospium ER (Sanctura XR, generics). Generic formulations of Detrol IR, Sanctura IR and Sanctura XR recently entered the market.

Step Therapy applies to this class. Step therapy involves prescribing a safe, cost effective medication as the first step in treating a medical condition. The preferred medication is often a generic mediation that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the first step medications are ineffective or poorly tolerated. All new and current OAB drug users are required to try Detrol LA, oxybutynin ER, oxybutynin IR or trospium IR before receiving Enablex, Toviaz, Detrol, Sanctura XR, Oxytrol, Gelnique 10%, or Vesicare.

Prior Authorization Criteria for OAB medications

Automated PA criteria: The patient has received a prescription for Detrol LA, oxybutynin IR, oxybutynin ER or trospium IR at any Military Health System pharmacy point of service (Military Treatment Facilities, retail network pharmacies, or mail order) during the previous 180 days, AND

Manual PA criteria, if automated criteria are not met (e.g., a trial of Detrol LA, oxybutynin IR, oxybutynin ER or trospium IR is not required) if:

1) The patient has experienced any of the following issues while receiving Detrol LA, oxybutynin IR, oxybutynin ER or trospium IR, which is not expected to occur with Detrol IR, Sanctura XR, Vesicare, Enablex, Toviaz, Oxytrol, or Gelnique 10%:
   - Inadequate response;
   - Intolerable adverse effects (e.g. the patient requires Sanctura XR due to intolerable dry mouth with Detrol LA); or,
   - Contraindication

Coverage is only approved for the following FDA-approved indications:

1) The patient has a confirmed diagnosis of OAB with symptoms of urge incontinence, urgency, and urinary frequency (for all 11 OAB drugs).
2) The patient is older than 6 years with symptoms of detrusor overactivity associated with a neurological condition (e.g., spina bifida), for oxybutynin ER. Other uses, including stress incontinence, will not be approved.

Criteria approved through the DoD P&T Committee process

www.tricare.mil is the official Web site of the
Defense Health Agency,
a component of the Military Health System
DHHQ, 7700 Arlington Blvd,
Falls Church, VA 22042

Prior Authorization Request Form for
tolterodine IR (Detrol),**darifenacin** (Enablex), **oxybutynin gel** (Gelnique), **oxybutynin transdermal patch** (Oxytrol), **trospium ER** (Sanctura XR), **fesoterodine** (Toviaz), **solifenacin** (Vesicare)

6006

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at: **http://pec.ha.osd.mil/forms_criteria.php.** This prior authorization has no expiration date.

Step 1
Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2
Which medication is being requested?

Please complete the clinical assessment:

1. Does the patient have a confirmed diagnosis of overactive bladder with symptoms of urge incontinence, urgency, and urinary frequency?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Has the patient had a trial of tolterodine extended-release (Detrol LA)**, oxybutynin IR, oxybutynin ER, or trospium immediate-release** (Sanctura immediate-release) **and experienced an inadequate response?**	☐ Yes Sign and date below	☐ No Proceed to Question 3
3. Has the patient had a trial of tolterodine extended-release (Detrol LA)**, oxybutynin IR, oxybutynin ER, or trospium immediate-release** (Sanctura immediate-release) **and experienced intolerable adverse effects?**	☐ Yes Sign and date below	☐ No Proceed to Question 4
4. Does the patient have a contraindication to tolterodine extended-release (Detrol LA)**, oxybutynin IR, oxybutynin ER, and trospium immediate-release** (Sanctura immediate-release) **which is not expected to occur with the requested medication?**	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3
I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[22 Jan 2014]